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THE ROLE OF INTERIOR DESIGN
IN
THE PSYCHOTHERAPIST'S OFFICE

By

Vincent J. Ylagan

Submitted in Partial Fulfillment
of the Requirements for
Graduation with Honors from the
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*Design is a plan for arranging elements
in such a way as best to accomplish a particular purpose.*

Charles Eames

Thesis Summary

The ways we choose to design the spaces we spend time in can have subtle but significant effects on how we feel and think. This study explored the influence of the interior design of psychotherapists' offices using two surveys sent to therapists, therapy clients, and individuals who have not been to therapy. A literature review identified aesthetic features of the therapist's office and their effects on several variables related to the therapeutic process. Therapists, clients, and individuals who have not been to therapy completed surveys to investigate and compare how the different populations view the "ideal" therapy office.

Abstract

A growing body of research in environmental and design psychology indicates that our surroundings can have subtle but significant effects on how we feel and think. One setting where thoughts and feelings are at the forefront of the work done is the psychotherapist's office, where clients go to process stressors and learn strategies to overcome emotional difficulties. The current study aimed to investigate how therapists and clients view the therapist office and identify the features associated with the "ideal" therapist office. Therapists, current or past therapy clients, and individuals who have not been to therapy completed short surveys. Surveys asked participants to rate how much attention they pay to interior design in general, as well as how much of an effect they believe the therapist office has on client perceptions of the therapist and therapy outcomes. Results indicated that clients pay a moderately significant amount of attention to their therapist's office. Therapists pay more attention to how their office looks and comes across than clients do and design their office equally for themselves and clients. Therapists and clients rated the therapy office as having a moderately significant effect on how clients view the therapist and the therapy office as having a moderately insignificant to moderate effect on therapy outcomes. Overall, therapists should not overlook the design of their office, as it is noticed by clients and may affect how they view their therapist.

Keywords: therapist office, aesthetics, environmental/design psychology, interior design, mood

The Role of Interior Design in the Psychotherapist's Office

As the famed mid-century modern designer Charles Eames once said, “Design is a plan for arranging elements in such a way as best to accomplish a particular purpose” (Carnegie Mellon School of Design, n.d.). Whether it be the architect drafting up a new house with form *and* function, or the social scientist debating whether to use a qualitative methodology or a quantitative one to best explore their topic of interest, professionals must carefully plan an outline or design for any undertaking. Psychologists and counselors are no different—just as the mental health professional uses a diagnosis and other client information to draft a treatment plan, they also have the opportunity to design and personalize their office space as they wish. Therapists do not engage in their work in a vacuum, but a physical space with material objects, sensory stimuli, and an assortment of symbols that represent much more than meets the eye. Despite being literally and figuratively in the background compared to the actual psychotherapy itself, the space in which therapy occurs offers a unique canvas that the therapist can use to disclose certain information about themselves and the work they do. Additionally, as Devlin and Nasar (2012) state, “In the context of the therapeutic environment, an orderly clinical setting may provide a sense of structure and predictability for the client whose own life may lack those reassuring characteristics.”

Research in the field of environmental psychology has shown that our surroundings can, and do, influence how we feel and think. From more noticeable stimuli such as the brightness, color, or temperature of a room, to more subtle features, like the number of diplomas displayed on a wall, what we notice about a room leads us to certain conclusions about the person that inhabits it, and the type and quality of the work that they do (Devlin et al., 2009; Kang et al.,

2019). A therapist's office can be considered an extension of the therapist themselves, provided that they are allowed to customize it to a certain degree. Much like the clothes a counselor wears, the way they style their hair, or the way they speak, how they choose to design and decorate their office communicates a wealth of information to clients, akin to an act of self-disclosure on a larger, physical scale.

The purpose of this study is twofold: to examine the literature on the effects of aesthetic features of a therapy space on several variables related to the therapeutic process, such as client perceptions of their therapist, client self-disclosure, and cultural competence, and to explore and compare how clients and therapists view the therapist office. Research on how mental health providers choose to arrange and decorate their room is relatively limited, as is research on the effects these aesthetic decisions have on clients' experiences in therapy. However, much more research has been done regarding the environmental design of other healthcare facilities such as hospitals (Devlin & Arneill, 2003). The interior design of the psychotherapist's office could very well be considered inconsequential compared to other research areas in clinical psychology and counselor education and supervision, such as diagnosis, treatment, or the therapeutic alliance, yet there is no doubt that we are influenced by the environments we inhabit.

Literature Review

A literature review was conducted using several electronic databases, including Google Scholar, PubMed Central, PsycInfo, PsychiatryOnline, and PsycArticles. Search terms included *therapist office*, *aesthetics*, *environmental/design psychology*, *interior design*, and *mood*. Several themes stood out in previous research, which included room size, seating, lighting, decor, plants, color, and olfactory and acoustic features. The current study focused primarily on features that

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contribute to the room's general atmosphere and are readily modifiable by mental health professionals. Special client populations, such as those who have physical disabilities or are part of the LGBTQ+ community, were also considered.

Room Size

Immediately upon entering their therapist's room, clients notice the relative size of an office space, whether consciously or unconsciously. The presence and size of chairs, couches, and desks significantly influence the perceived size of the office space as a whole. A desk may be present in the office to distinguish where the therapist sits and where the client sits, but whether or not the therapist will choose to sit behind their desk or in front of it, closer to the client, is up to them. Variables such as desk size may play a role in how clients perceive their therapist. One study from 1984 found that male clients had more positive perceptions of their therapist if they were seated behind a desk, while female clients preferred their therapist to sit in front of their desk (Gass, 1984). Another study showed that a relationship existed between the size of a desk, the size of the room it was in, and self-disclosure (the act of communicating personal information to another) in hypothetical patients (Okken et al., 2012). Specifically, participants presented with a hypothetical therapy room rated the room more comfortable and were more likely to reveal personal information if the room was larger and included a large desk. Among real therapist offices, participants least liked the rooms rated as "cramped" and "uncomfortable." Ultimately, clients may feel more comfortable when there is a larger amount of interpersonal distance between them and their therapist, and when the room they are in does not feel stiflingly small.

Seating

After entering the therapy office, clients take note of where they will sit and must differentiate between their chair and that of their therapist. Therapists must consider where they will sit in relation to their client during the session. No longer as common in the therapy office is the Freudian couch, on which a patient would recline while his or her psychoanalyst would sit behind them, out of view. Carl Jung in particular was an avid proponent of sitting face-to-face with his patients, who were free to look at him as they pleased and witness his reactions to what they said in session (Lingiardi & De Bei, 2011).

Questions mental health professionals must consider when planning their office include whether or not the type of chair that the therapist sits in is different from that of their clients, whether to set the therapist and the client at an angle or directly facing each other, and how close they are to each other (Kiernan et al., 1989). Kiernan and his colleagues sent out a questionnaire to 255 randomly chosen psychiatrists in the United States, assessing how they laid out their office. Most respondents indicated that they sat in different style chairs from their patients, while about half sat at an angle from their patients. Most psychiatrists indicated that their office was primarily designed for both themselves and their patient and believed that it had a moderate effect on therapy. Functional and ergonomic constraints, such as the fact that the mental health provider spends hours every day sitting in the same chair, while the client only sits in their chair or couch for an hour or so, also influence a provider's choice of seating. Ergonomics cannot be ignored, particularly when it comes to seating, and chairs that can be adjusted and modified according to the user's tastes are of the utmost importance for sedentary jobs (Saklani & Jha, 2011).

Lighting

Individuals perceive the lighting and brightness of a room as soon as they enter. Thanks to the availability of light bulbs that can be controlled from one's personal device, the opportunities for customization and personalization of lighting are endless. Smart technology is becoming increasingly accessible and packed with features, and smart light bulbs are often more energy efficient than traditional fluorescent and incandescent light bulbs. Owners of smart light bulbs can easily adjust their brightness and temperature levels to create an optimally lit environment that suits their needs.

Kang and colleagues (2019) studied the effects of color temperature and brightness on self-control, emotional temperature, and cognitive fluency. Cognitive or processing fluency is exhibited when receiving info that coincides with expectations or previous information; in other words, when perceiving a stimulus that “feels right.” Bright yellow light felt more natural and cognitively fluent to participants than did bright blue light. Participants associated bright lighting with yellow, warm feelings, while they associated dark lighting with blue, cold feelings. In both a warm, bright room and a cool, dark room, participants were more likely to delay pleasure and do a difficult task for future benefit and, when presented with a hypothetical decision, choose the more utilitarian option over a more hedonic option. Less fluent lighting conditions were associated with less self-control. Therapists may want to consider a warm and bright lighting scheme in their office, which may make it easier for clients to participate in the often-difficult work of therapy and self-reflection.

The effect brightness has on client self-disclosure is less clear. One study conducted in Japan looked at how brightness and the presence of home-like decorations in the therapy space affected the duration of clients' speaking times (Miwa & Hanyu, 2006). Participants in the study,

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who were undergraduate university students acting as hypothetical clients, in the dimly lit room spoke significantly longer than those in the bright room, and dim lighting was rated as calmer, more pleasant, and relaxing than bright lighting. Clients rated therapists as more good-humored and pleasant under dim lighting. Interestingly, the presence of decorations did not have any significant effect on clients' speaking times. On the other hand, a study by Okken and her colleagues (2013) found that, when presented with a hypothetical picture of a bright doctor's office, participants rated themselves more likely to self-disclose than when presented with a picture of a darker office. When participants were presented with a more threatening hypothetical situation that involved uncertainty and negative information, a brighter room led to greater intent to actively participate in conversation and descriptively respond to questions, higher perceived spaciousness of the office, a more positive affect, and a more positive perception of their hypothetical physician.

Mental health providers may want to consider purchasing lights whose brightness, or even color temperature, can be modified by the provider or client as they wish, to cultivate a more personalized, comfortable environment during therapy. Clients may perceive fluorescent overhead lights as too harsh and may prefer softer, indirect lighting instead. Anecdotal reports as well as studies have shown that fluorescent lights may cause headaches and eyestrain in individuals (Winterbottom & Wilkins, 2009).

Wall Décor

Decorations and art on the wall can serve as an opportunity for the therapist to disclose information about themselves or their background. Family photos, diplomas, posters, paintings, and tapestries are all items that a mental health provider may choose to display on their office

walls. One study presented participants with photos of a hypothetical therapy office that had either zero, two, four, or nine credentials, such as diplomas, displayed on the wall and either zero or two family photos (Devlin et al., 2009). Participants rated rooms with four or nine credentials on the wall, compared to the rooms with zero or two credentials, as belonging to therapists who were friendlier, more qualified, and energetic. The number of family photos displayed had no significant effect on therapists' rated friendliness, qualifications, or energy, but overall therapist quality ratings were more positive when they were present. Of course, therapists must consider the implications of displaying such personal items as family photos, as clients coming in to discuss family-related issues may be particularly sensitive to seeing such decor displayed.

Office Décor

What furniture to place in one's office and what type of general atmosphere to create are two of the most important questions a therapist must ask when considering their office space. One study examined how styles of office décor and the sex of the therapist influenced client perceptions and found that female therapists in more traditional or professionally styled offices were rated as more credible than those in more casually styled offices, while male therapists in more casually styled offices were rated as more credible than those in more traditional offices (Bloom et al., 1977). Another study found that the presence of decorations in the therapy space did not have any significant effect on client speaking times or client ratings of the therapist on calmness, pleasantness, or relaxation (Miwa & Hanyu, 2006)

Clients from a multicultural background may benefit from seeing culturally diverse decor in their therapist's office by feeling more comfortable and welcomed. Unfortunately, members of minority groups, particularly those from immigrant communities, are less likely to seek mental

health treatment, but more and more individuals from diverse backgrounds are beginning to take advantage of therapy (Devlin et al., 2013). Devlin and her colleagues examined the effect of the presence of multicultural items on clients' perception of their therapist's characteristics and found interesting results. One of four photographs of a hypothetical therapist office were presented to participants, and offices either had one decorative item present or six, with items either belonging to a "Western tradition" or a "multicultural tradition." Decorative items in the Western tradition included a poster of a Van Gogh painting, a bell, and a ceramic model of a beach house, while items in the multicultural tradition included a statue of the Hindu god Ganesh, a Kenyan Masai mask, and textiles from Pakistan. Participants were then asked to rate characteristics, such as multicultural sensitivity, about the therapist whose office they viewed. Ultimately, participants who were shown photographs of the multicultural-styled office rated the therapist inhabiting the office as more multiculturally welcoming.

Clinicians, whether they are from a multicultural background or not, could consider placing a selection of diverse, culturally meaningful objects or decorations in their office. Clients from diverse backgrounds may notice these features and feel more welcomed by their therapist, and their therapist may be viewed as more culturally competent than if they were to display more traditional, western decorations.

Plants

Plants are one feature that therapists can easily incorporate into their office space and have been shown in some studies to potentially provide psychological benefits (Bringslimark et al., 2009). People have been placing plants inside buildings as far back as the third century BC in ancient Egypt, and the advent of indoor heating has allowed individuals to bring tropical and

subtropical plants inside. One article that surveyed psychiatrists on the interior design of their office space pondered, “What message does the presence of a plant impart on the patient: that the therapist is relaxed; interested in things other than cold, hard science; is participating in growth?” (Kiernan et al., 1989).

Despite an intuitive positive association between the presence of plants and such benefits as improved mood or cognitive performance, the few experimental studies conducted on plants' psychological effects have mixed results (see review by Bringslimark et al., 2009). In one study, the presence of plants in a hospital dining room increased the amount of time spent in the room as well as the amount of food consumed; indoor plants have also been demonstrated to increase pain tolerance and contribute to more positive impressions of the room they are in. Alternatively, several other experimental studies did not yield any significant effects from plants, with no significant changes found in blood pressure or the temperature of skin on individuals' extremities (with an increase in skin temperature indicating a reduction of stress) after being exposed to them. Even if there is a lack of definitive data on the positive effects of indoor plants, there may be no harm in including a plant or flower (or two, or more) in one's office space (provided that neither therapist nor client is allergic to pollen or spores).

Color

Colors are an important part of interior design and are an opportunity for an individual to drastically change the ambience of a room. Therapists can include color in their office space by using paint or wallpaper, wall art, tapestries, desks, tables, bookshelves, and seating, which all come in a variety of shades and patterns. One study found that a light blue color, similar to the shade of blue found on Twitter's logo, was the most favorable color for a counseling room, as

determined by the highest ratings for pleasantness, interest, excitement, relaxation, safety, and activity (W. Liu et al., 2014).

Olfactory and Acoustic Features

Individuals also notice the aroma or smell of a room as soon as they walk in. Mental health providers may want to ensure that their office space has either no aroma or a neutral one, especially during their first sessions with potential clients, where first impressions may play a significant role in the client's decision to continue therapy with the provider. One's memory, emotions, and sense of smell are closely linked through the limbic system, and unpleasant smells have been found to elicit negative memories, and vice versa (M. Liu et al., 2004; Pressly & Heesacker, 2001). It should be noted that the concept of aromatherapy is not scientifically backed, but olfactory stimulation or remediation has been studied; one study found that fragrances of foods, such as fruit, inhaled by patients led to a reduction in depressive symptoms. Almond, heliotropin, gardenia, rose, and lavender scents have been empirically shown to elicit positive effects such as increased interpersonal attraction, improved affect, and heightened task performance (M. Liu et al., 2004).

In terms of acoustics, clients may notice background noise or noise pollution in therapy sessions, particularly at points in the conversation when neither the client nor therapist is speaking. A large amount of background noise can lead to difficulties concentrating, headaches, increased blood pressure, and irritability and is particularly unfavorable when conversations such as those in psychotherapy are occurring (Pressly & Heesacker, 2001). As in any healthcare setting, privacy is incredibly important, and clients in their therapist's office should not be able to overhear conversations occurring near the therapy room, or have their conversations overheard

by individuals outside the therapy room. White noise machines, other sound-generating devices, or even videos available on YouTube of repetitive nature sounds like ocean waves can be placed or played inside a therapist's office to drown out any background noise and create a calming environment. Clinicians may want to consider items such as curtains, rugs, or acoustic tiles that can dampen any excess noise or minimize the area of exposed surfaces like glass and concrete that may reflect sounds back to listeners.

Special Populations

There are several populations that should be considered when designing a physically accessible, multicultural, and accepting therapy space for all clients. One study surveying healthcare clinics found a gap between the Americans with Disabilities Act (ADA) guidelines for accessibility for those with spinal cord injuries requiring the use of a wheelchair and the actual accessibility of clinics (Sanchez et al., 2000). To comply with ADA guidelines, entryways and therapy offices should be large enough for a person using a wheelchair to enter the room as well as any associated bathrooms.

Another population to consider when thoughtfully designing a therapy space is the LGBTQ+ community. A wide body of research has indicated that members of the LGBTQ+ community are at a higher risk of developing mental illness than heterosexual individuals are (Meyer, 2003). Programs and initiatives on college and university campuses to make the school environment safer for LGBTQ+ individuals have existed since the 1990s and have made their way to high schools, non-profits, and healthcare settings (Sadowski, n.d.). Mental health providers can seek out "safe zone" or "safe space" stickers that they can place on their door or somewhere else noticeable to clients to indicate openness towards and acceptance for non-

heterosexual individuals, and to suggest that their clients need not fear bringing up the topic of sexuality in therapy sessions.

Current Study

This study aimed to investigate how therapists and clients view the therapy office and identify the features associated with the “ideal” therapy office. Individuals who have been to therapy completed short surveys and answered questions about the effects of their therapist's office's interior design on their therapy. Active mental health professionals also completed surveys and rated the size of the effect of their office's interior design on patients' outcomes, their predictions for how much attention clients pay to their office, and whether they design their office more for themselves or their clients. This study aimed to add to the limited research that has been done to directly ask therapists and therapy clients about the impact of interior design on therapeutic practice.

Women were predicted to pay significantly more attention to the interior design of the spaces they spend time in, compared to men. Reports from interior design programs and journals in North America, as well as gender stereotypes, would suggest that interior design is a field and interest dominated by either women (or gay men; Matthews & Hill, 2011). Based on a study from 1989 that surveyed psychiatrists and found that most believed the design of their office had a moderate effect on therapy, it was predicted that therapists and clients believe that the therapist's office has a moderate effect on therapy outcomes (Kiernan et al.). To the best of the author's knowledge, there has not been any previous research examining whether therapists and clients pay the same amount of attention to the therapy office, how much the appearance of the therapy office affects how clients view the therapist, and how much of an effect the therapy

office has on client outcomes specifically (as opposed to the therapy as a whole), as rated by therapists and clients. There are also no known studies comparing therapist and client opinions on specific objects that should or should not be included in the “ideal” therapy room. However, one previous study showed a moderate level of similarity between therapist and client ratings for quality of care, comfort, therapist qualifications, boldness, and friendliness after both groups were presented with images of actual therapist offices (Devlin & Nasar, 2012). Based on this research, therapists and clients were predicted to pay the same amount of attention to the therapist's office, and both groups were predicted to have similar ratings for how much the therapist office's appearance affects client perceptions of the therapist.

Methods

Participant Demographics

To conduct this study, two surveys were sent out: a “client/non-client” survey for individuals who have or have not previously attended at least one psychotherapy or counseling session, and a “therapist” survey for currently practicing mental health providers.

Participants for the client/non-client survey were recruited mostly from students at the University of South Carolina. A link to the survey was disseminated through GroupMe, Snapchat, SMS messages, emails to a psychology professor's classes, or the university's department of psychology research participant portal, the SONA System. One hundred forty-four participants completed the survey: 125 women (86.8%), 16 men (11.1%), one individual who identified as non-binary (0.7%), one individual (0.7%) who identified as transmasculine agender, and one individual (0.7%) who identified as agender. Ages ranged from 13 to 41 years, with a mean of 20.39 years and a standard deviation of 2.89 years. One hundred twenty-three participants (85.4%) identified as white, 16 participants (11.1%) identified as Asian, nine participants (6.3%) identified as African American/Black, two participants (1.4%) identified as American Indian or Alaskan native, and one (0.7%) identified as Hispanic or Latinx. Most participants (100, 69.4%) answered that they have been to at least one therapy session. See Table 1 for complete demographic data.

Participants for the therapist survey were recruited through email listservs or personal emails. Thirty-four participants completed the survey: seven men (20.6%) and 27 women (79.4%). Ages ranged from 26 to 72 years, with a mean of 44.38 years and a standard deviation of 14.72 years. Thirty participants (88.2%) identified as white, two (5.9%) preferred not to

answer, one (2.9%) identified as African American/Black, and one (2.9%) identified as Hispanic or Latinx. Most mental health providers surveyed had PhDs (20 participants, 58.8%), followed by PsyDs (seven participants, 20.6%), Master's degrees (seven participants, 17.6%), and DMin (Doctor of Ministry; one participant, 2.9%). Years practicing as a mental health provider ranged from 0.75 to 42 years, with a mean of 13.89 years and a standard deviation of 12.67 years.

Materials and Procedure

The two surveys were created using Google Forms. As per the university's Office of Research Compliance, Institutional Review Board (IRB) approval for the current study was not required as it constituted an honors thesis conducted for the student's benefit. See Figure 2 in the Appendix for questions asked to clients and non-clients and Figure 3 for questions asked to therapists. Answer choices for most questions in both the client/non-client survey and therapist survey were presented on a Likert scale from 1 to 5. Depending on the question, 1 represented "no attention", "no effect", or "for myself", 3 represented "a moderate amount of attention", "a moderate effect", or "equally for myself and for my clients", and 5 represented "a significant amount of attention", "a significant effect", or "for my clients." Depending on the participant's answer to the question "Have you been to at least one therapy/counseling session before?", the survey sent to clients (those who had been to at least one therapy session) and non-clients (those who had never been to therapy) branched into two separate sections with different questions. Non-clients were asked to respond to fewer questions than clients and were only asked about how much attention they pay to the interior design of the spaces they spend time in and about what features should and should not be included in the "ideal" therapy office. In the client and therapist survey, the questions assessing the effect of the therapist's office on therapy outcomes

and whether therapists designed their office more for themselves or for their clients were based on similar questions originally asked in a 1989 survey of American psychiatrists that explored how they arranged their office space (Kiernan et al.).

Statistical Analyses

Using SPSS, descriptive statistics were calculated for participant demographics and the series of Likert-scale questions concerning therapists' offices for both client/non-client and therapist surveys. Using data from therapists and individuals who have been to therapy (clients) and who have not been to therapy (non-clients), an independent samples one-tailed *t*-test was conducted to determine whether women pay significantly more attention to the interior design of the spaces they spend time in than men do. Using Google Forms, the most frequently selected responses to the questions "What should be included in the 'ideal' therapy room?" and "What should *not* be included in the 'ideal' therapy room?" were identified for therapist, client, and non-client populations.

To compare how therapists and clients view the therapy office, independent samples two-tailed *t*-tests were conducted to determine if therapists differ from clients in the amount of attention they pay to the therapy office, if therapists' predictions for how much attention clients pay to the therapy office are different from clients' actual ratings, if therapists differ from clients in their ratings of the size of effect the therapy office has on how clients view the therapist, and if therapists differ from clients in their ratings of the size of an effect the therapy office has on therapy outcomes.

Results

Clients

Using a Likert scale from 1 to 5 (with 1 representing “no attention” or “no effect”, 3 representing “a moderate amount of attention” or “a moderate effect”, and 5 representing “a significant amount of attention” or “a significant effect”), most clients who were surveyed reported paying a moderately significant amount of attention to the interior design of the spaces they spend time in ($M = 3.71$, $SD = 1.04$). Clients most frequently reported paying a moderately significant amount of attention to how their therapist's office looks and comes across ($M = 3.46$, $SD = 1.27$). Most clients reported thinking their therapist's office has a moderately significant effect on how they view their therapist ($M = 3.81$, $SD = 0.96$). Lastly, most clients reported thinking their therapist's office has a moderate effect on their therapy outcomes ($M = 2.70$, $SD = 1.07$). See Table 2 for complete descriptive statistics and Figures 2-6 for bar graphs of responses.

Non-Clients

Using a Likert scale from 1 to 5 (with 1 representing “no attention”, 3 representing “a moderate amount of attention”, and 5 representing “a significant amount of attention”), most individuals who have not been to therapy reported paying a moderately significant amount of attention to the interior design of the spaces they spend time in ($M = 3.48$, $SD = 1.00$). See Table 2 for complete descriptive statistics and Figure 7 for a bar graph of responses. There was not a significant difference between clients and non-clients in how much attention they pay to the interior design of the spaces they inhabit, as shown by an independent samples t -test, $t(142) = 1.25$, $p = 2.12$, two-tailed.

Therapists

Interior Design of the Psychotherapist's Office

Using a Likert scale from 1 to 5 (with 1 representing “no attention” or “no effect”, 3 representing “a moderate amount of attention” or “a moderate effect”, and 5 representing “a significant amount of attention” or “a significant effect”), most therapists reported paying a moderate amount of attention to the interior design of the spaces they spend time in ($M = 3.79$, $SD = 1.01$). Most therapists reported paying a significant amount of attention to how their office looks and comes across to clients ($M = 4.06$, $SD = 1.04$). Most therapists think their clients pay a moderately significant amount of attention to the interior design of their office ($M = 3.79$, $SD = 0.85$). The majority of therapists rated their office as having a moderately significant effect on how their clients view them as a therapist ($M = 3.71$, $SD = 0.80$). Therapists most frequently rated their office as having a moderate effect on their clients' therapy outcomes ($M = 2.44$, $SD = 0.99$). Using a Likert scale where 1 represented “for the therapist” and 5 represented “for the client”, most therapists reported designing their office equally for themselves and their clients ($M = 3.12$, $SD = 1.12$). See Table 2 for complete descriptive statistics and Figures 8-13 for bar graphs of responses.

Gender and Attention to Interior Design in General

An independent samples t -test was conducted to determine if men ($M = 3.57$, $SD = 0.90$) paid less attention to the interior design of the spaces they spend time in compared to women ($M = 3.68$, $SD = 1.05$). There was not a significant difference between the two groups $t(173) = 0.52$, $p = 0.36$, one-tailed, indicating that women and men pay approximately the same amount of attention to interior design overall.

Attention to the Therapy Office

An independent samples *t*-test was conducted to determine if therapists ($M = 4.06$, $SD = 1.04$) pay different amounts of attention to how their office looks and comes across, compared to their clients ($M = 3.46$, $SD = 1.27$). There was a significant difference between the two groups $t(132) = -2.48$, $p = 0.01$, two-tailed, indicating that therapists pay significantly more attention to the interior design of their office than clients do.

Another independent samples *t*-test was conducted to determine if therapists' predictions ($M = 3.79$, $SD = 0.85$) for how much attention clients pay to the therapist office significantly differ from clients' actual ratings ($M = 3.46$, $SD = 1.27$). The two groups' responses were not significantly different, $t(132) = 1.43$, $p = 0.16$, two-tailed, indicating that therapists accurately predicted that clients pay a moderate to moderately significant amount of attention to how the therapy office looks and comes across.

The Therapy Office and Therapy Outcomes

Another independent samples *t*-test was conducted to determine if therapists ($M = 2.44$, $SD = 0.99$) differ in how much of an effect they think their office space has on clients' therapy outcomes ($M = 2.70$, $SD = 1.07$). There was not a significant difference between the two groups, $t(132) = -1.24$, $p = 0.22$, two-tailed, indicating that therapists and clients believe that the therapy office has a moderately insignificant to moderate effect on therapy outcomes.

The Therapy Office and Therapist Perceptions

An independent samples *t*-test was conducted to determine if therapists ($M = 3.71$, $SD = 0.80$) differ in how much of an effect they think their office space has on how clients view them as a therapist, compared to their clients ($M = 3.81$, $SD = 0.96$). There was not a significant

difference between the two groups, $t(132) = -0.57$, $p = 0.57$, two-tailed, indicating that therapists and clients think that the therapy office has a moderately significant effect on how clients view the therapist.

Characteristics of the “Ideal” Therapy Office

The top five most frequent responses from clients to the question “What do you think should be included in the ‘ideal’ therapy office?” were, in descending order, a home-like atmosphere; a window; soft, dim lighting; plants; and a soothing color palette. The top five most frequent responses to the question “What do you think should *not* be included in the ‘ideal’ therapy office?” were, in descending order, bright lighting, religious or spiritual symbols or objects, a clock facing the client, therapist’s family photos, and a professional atmosphere. See Figures 14-15 in the Appendix for bar graphs of responses to both questions.

The top five most frequent responses from non-clients to the question “Even if you have not been to therapy, what do you think should be included in the ‘ideal’ therapy office?” were, in descending order, a window; a home-like atmosphere; soft, dim lighting; diplomas or credentials; and a soothing color palette and plants (with both being the fifth most frequently selected responses). The top five most frequent responses to the question “What do you think should *not* be included in the ‘ideal’ therapy office?” were, in descending order, religious or spiritual symbols or objects, a clock facing the client, bright lighting, therapist’s family photos, and a professional atmosphere. See Figures 16-17 in the Appendix for bar graphs of complete responses to both questions.

The top five most frequent responses from therapists to the question “What do you think should be included in the ‘ideal’ therapy office?” were, in descending order, diplomas or

credentials and facial tissues (with both being the most frequently selected responses); a soothing color palette; and soft, dim lighting and a window (with both being the third most frequently selected responses). The top five most frequent responses to the question “What do you think should *not* be included in the ‘ideal’ therapy office?” were, in descending order, religious or spiritual symbols or objects, bright lighting, therapist’s family photos, a clock facing the client, and a home-like atmosphere. See Figures 18-19 in the Appendix for bar graphs of complete responses to both questions.

Correlation Analyses

Two-tailed Pearson correlation analyses were conducted to determine if there was a relationship between the amount of attention clients and therapists pay to interior design in general and their ratings for how much of an effect the therapist office has on clients’ therapy outcomes, and if there was a relationship between the amount of attention clients and therapists pay to the therapist office and their ratings for how much of an effect the therapist office has on clients’ therapy outcomes. There was a significant positive correlation between attention to interior design in general and ratings for the office’s effect on clients’ outcomes, $r(132) = .705, p < .001$, two-tailed. Additionally, there was a significant positive correlation between attention to the therapist office and ratings for the office’s effect on clients’ outcomes, $r(132) = .776, p < .001$, two-tailed. See Figures 20-21 for scatterplots of both correlation analyses.

Discussion

The present study examined how therapists and therapy clients view the therapist office and identified several characteristics that belong in the “ideal” therapy office, as rated by therapists, clients, and individuals who have not been to therapy. There were several hypotheses proposed. Women were predicted to pay significantly more attention to the interior design of the spaces they spend time in, compared to men. Therapists and clients were predicted to rate the therapy office as having a moderate effect on therapy outcomes. Therapists and clients were predicted to pay similar levels of attention to the therapy office and to have similar ratings for how much of an effect the therapy office has on how clients view the therapist.

The first hypothesis was not supported. Women and men did not significantly differ in the amount of attention they pay to the interior design of the spaces they spend time in, but mean scores for women were slightly higher than men's scores. Data partially supported the second hypothesis. Therapists and clients believe that the therapy office has a moderately insignificant to moderate effect on therapy outcomes. On average, therapists were more likely than clients to answer that it had a moderately insignificant effect, despite therapists reporting that they pay more attention to their office's appearances than clients do. It is possible that therapists and clients are more likely to notice and be at least subtly influenced by extremes in the therapist office—for example, a sparse, organized room versus a cluttered, busy one—while a neutral, more generically decorated room goes unnoticed. Practicing therapists may be more of the opinion that the non-visual aspects of therapy, such as cultivating the therapeutic alliance and picking an evidence-based treatment, play a larger role in influencing therapy outcomes than their office's appearance does. While the interior design of the therapy office may have at least a

subtle effect on the therapy process as a whole, there may be a “point of diminishing returns” associated with them; after all, clients are, first and foremost, coming to their therapist's office to receive treatment through therapy or counseling, and not through simply spending time in a comfortable room, no matter how aesthetically pleasing it might be.

Data did not support the third hypothesis; therapists pay more attention to how their office looks and comes across than clients do. However, therapists did accurately predict that clients pay a moderate to moderately significant amount of attention to the therapy office. Since therapists spend much more time in their office than their clients do, it would be reasonable that they are more attuned to their office's appearance and more intentional about how it comes across than clients are.

Data from the surveys supported the fourth hypothesis. Both therapists and clients have similar ratings for how much of an effect the therapy office has on how clients view the therapist, with both groups believing that it has a moderately significant effect on client perceptions of the therapist. This is in line with previous research, which finds that the therapist's office can indeed be considered an extension of the therapist and communicate information about them. Studies have shown that qualifications, friendliness, energy, credibility, and competence are all examples of therapist characteristics that are associated with certain features of the therapy room and that have a moderate level of similarity in therapists' and clients' ratings of therapy rooms (Amira & Abramowitz, 1979; Bloom et al., 1977; Devlin et al., 2009).

Regarding participants' responses for what should and should not be in the “ideal” therapy office, several findings are noteworthy. Therapists, clients, and non-clients alike all appreciate the presence of a window; a soothing color palette; and soft, dim lighting in the

therapy office. Alternatively, all three groups of participants frequently selected bright lighting, therapist's family photos, religious or spiritual symbols or objects, and a clock facing the client as characteristics that should *not* be in the ideal therapy office. Clients and non-clients ranked a home-like atmosphere as high on the list in an ideal therapy office and a professional atmosphere as something that should not be in a therapy office, while practicing therapists answered in the opposite way, preferring a professional atmosphere over a home-like one. The client/non-client population surveyed was significantly younger than the therapist population; the average client/non-client was about 20 years old, while the average therapist was about 44 years old. Younger populations may prefer a more comfortable and casual environment in which to participate in therapy, compared to more traditional, professional surroundings. Also, despite mixed findings in the literature about indoor plants' positive effects, they were in clients' and non-clients' top five characteristics of the ideal therapy office. However, only about a third of the therapists included plants in their top five responses.

Two additional analyses were conducted to determine if a correlation existed between the amount of attention clients and therapists pay to interior design in general and their ratings for how much of an effect the therapist office has on clients' therapy outcomes, and if a correlation existed between the amount of attention both groups pay to the therapist office and their ratings for how much of an effect the therapist office has on clients' therapy outcomes. Significant positive correlations were found for analyses, indicating that individuals who are more attuned to interior design are more likely to attribute more of an effect from the therapist office on treatment outcomes.

Limitations

The current study has several limitations. Results from the client/non-client survey may not be fully generalizable, as convenience sampling resulted in most participants being college students, specifically psychology majors, at a large public university in the southeast. In addition, the majority of participants for both the therapist and client/non-client surveys were white, which coincides with current statistics on psychologist and client demographics (Hayes et al., 2016; Lin et al., 2018). Only slightly more than 10% of clients and non-clients surveyed identified as men, while about 20% of therapists surveyed identified as men. Self-selection and volunteer bias may have influenced results; individuals who have a less neutral or firmer opinion on interior design and the therapist office may have been more likely to participate in the study and complete the surveys. Both surveys were not tested for reliability or validity, bringing into question how closely and accurately they examined participants' views on interior design and the therapy office. Since a variety of methods were used to disseminate the surveys, response rates are unknown. The question asking how much the appearance of the therapy office affects how clients view the therapist was particularly broad and did not ask about specific therapist characteristics such as expertise or cultural competence. The therapist survey had a relatively small sample size of only 34 professionals, with less than one-fifth of participants being Master's-level clinicians.

Future Directions

In the future, interviews with therapists, clients, and non-clients could yield both broader and more concise data on what the ideal therapy office looks like and how to realistically achieve it. Therapists could be asked if the therapy space has ever been commented on by a client or used as a tool in therapy. Non-clients could be asked what comes to mind when they think of the

typical therapist's office, and clients could be directly asked the features in their therapist's office that they deem positive or negative. Clients could be asked to elaborate on what a "home-like" and comfortable atmosphere means to them. More clients who are not college-educated and a more racially and ethnically diverse sample could shed light on how to design the therapy office to be more welcoming to different backgrounds and how therapists can communicate that they are culturally competent and willing to explore issues like race. Only 20% of clients and 17.6% of therapists surveyed included multicultural art or décor in their top five characteristics of the ideal therapy office, while 31.8% of non-clients selected it. With a relatively low number of clients and therapists considering multicultural items important enough to be in the ideal office, other factors that do not relate to interior design, such as the therapist's own visible racial and ethnic background or an explicit emphasis on cultural responsiveness, may have more of a palpable effect on clients. Particularly for white therapists, the issue of whether or not to include multicultural objects or décor in their office is another avenue that future research could explore. Would clients of color find multicultural items in their white therapist's office beneficial, or would it come across as disingenuous or insensitive? In the same way that traditional healthcare clinics might, are therapy offices designed to be welcoming to individuals of all backgrounds and identities, or do they cater to a certain population and ignore others?

Therapists of color and younger therapists would be another group to recruit for a future study to learn more about how to design a more inclusive therapy space. More and more individuals are seeking therapists who share their cultural background, especially to discuss topics like their racial identity and lived experiences as BIPOC, and younger generations as a whole are becoming more accepting of mental health issues and going to therapy. In the therapy

Interior Design of the Psychotherapist's Office

room, an awareness for diversity and a commitment to equity and inclusion will be increasingly important as the United States becomes more diverse. In the 2000 U.S. census, approximately 25%-30% of the population considered themselves part of a racial or ethnic minority group; this number is expected to rise to 47.5% by 2050, with the Latinx and Asian populations making up a large portion of the increase (Yali & Revenson, 2004). Despite the rise in racial and ethnic diversity in the U.S., the majority of psychologists in the country are white; minorities make up only 16% of the psychology workforce, according to a 2016 survey by the American Psychological Association (Lin et al., 2018).

Most participants of both the therapist survey and the client/non-client survey identified as women. Previous research on the college student population has found that female students are, on average, more open to seeking psychological help than male students are; also, men in general are less likely to seek help (such as for medical reasons) than women, due to a variety of reasons such as stigma and restrictive, traditional ideals of masculinity (Addis & Mahalik, 2003; Leong & Zachar, 1999). Men of all ages, racial and ethnic identities, and sexual orientations could be interviewed and asked about what aspects of therapists' offices could be modified, or what therapists in general could do to help break down the existing barriers discouraging them from seeking psychological help. Investigating ways to make the therapy space more inviting and contemporary could encourage more potential clients to seek out treatment and help lessen existing disparities in treatment use among populations who are minoritized and currently under-utilize mental health services.

Also, despite how the "therapist" survey was intended for any type of mental health professional, no psychiatrists, psychiatric physician assistants, or psychiatric mental health nurse

practitioners responded. Meeting with a psychiatric provider can often be a much more stressful experience than meeting with a therapist, even if patients who see different providers for medication and therapy often see their medication provider less frequently and spend much less time in their psychopharmacologist's office than in their therapist's office. More research could be done to identify how psychiatric professionals currently design their office spaces and to consider what aesthetic elements could be modified to make patients more comfortable and open with their provider, especially since the last known survey on the topic was sent to psychiatrists in 1989. Since the current study was merely observational, future experimental studies could manipulate real therapist's offices or pictures to determine if any aesthetic features in the therapy office are salient enough to influence variables in therapy, like client speaking times.

The findings from the present study add to the relatively small body of research studying the interior design of the therapy office and its potential implications. The design of the therapy office does not go unnoticed, with clients and therapists paying a moderately significant to significant amount of attention to it. In addition, the therapy office has a moderately significant effect on how clients view the therapist, as well as a moderate effect on therapy outcomes, as rated by clients and therapists. The presence of a window, a soothing color palette, and soft, dim lighting are a few of the most commonly selected characteristics of the ideal therapy office. Future studies would do well to include a larger number of younger, more racially and ethnically diverse therapists, as well as more diverse clients and non-clients who have varying levels of education. Overall, the current study offers therapists a number of points to consider when designing their office space to be a welcoming, comfortable environment that accurately and

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favorably represents them and allows both the therapist and client to do their best work in sessions.

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Appendix

Table 1.
Participant Demographics

Variable	Total Sample	Client/Non-Client	Therapist
Gender			
n	178	144	34
% Male	12.9	11.1	20.6
% Female	85.4	86.8	79.4
% Non-binary	0.57	0.7	-
% Transmasculine Agender	0.57	0.7	-
% Agender	0.57	0.7	-
Race			
n	178	144	34
% White	86	85.4	88.2
% Asian	9	11.1	-
% African American/Black	5.6	6.3	2.9
% American Indian or Alaskan Native	1.1	1.4	-
% Hispanic or Latinx	1.1	0.7	2.9
% Prefer not to answer	1.1	-	5.9
Been to Therapy Before?			
n	-	144	-
% Yes	-	69.4	-
% No	-	30.6	-
Degree Held			
n	-	-	34
% PhD	-	-	58.8
% PsyD	-	-	20.6
% Master's	-	-	17.6
% DMin	-	-	2.9

Table 2.
Descriptive Statistics of Participant Groups

Variable	Non-Clients		Clients		Therapist	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Attention to Interior Design in General	3.48	1.00	3.71	1.04	3.79	1.01
Self-Reported Attention to Therapist Office	-	-	3.46	1.27	4.06	1.04
Therapist-Reported Client Attention to Therapist Office	-	-	-	-	3.79	0.85
Effect of Therapist Office on Therapist Perceptions	-	-	3.81	0.96	3.71	0.80

Effect of Therapist Office on Therapy Outcomes	-	-	2.70	1.07	2.44	0.99
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Table 3.
Results of T-Tests

Analysis	Client		Therapist		<i>t</i>	<i>p</i>	<i>df</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Attention to Therapist Office	3.46	1.27	4.06	1.04	-2.48	0.01*	132
Client Attention to Therapist Office	3.46	1.27	3.79	0.85	1.43	0.16	132
Effect of Therapist Office on Therapist Perceptions	3.81	0.96	3.71	0.80	-0.57	0.57	132
Effect of Therapist Office on Therapy Outcomes	2.70	1.07	2.44	0.99	-1.24	0.22	132

* $p < 0.05$.

Figure 1.

Survey Questions to Individuals who Have or Have Not Been to Therapy

1. What is your gender identity?
2. What is your race/ethnicity?
3. What is your age?
4. Have you been to at least one therapy/counseling session before?
 - a. If yes:
 - i. How much attention do you pay to the interior design of the spaces you spend time in?
 - ii. How much attention do you pay to how your therapist's office looks and comes across?
 - iii. How much of an effect do you think your therapist's office has on how you view them as a therapist?
 - iv. How much of an effect do you think your therapist's office has on your therapy outcomes?
 - v. What do you think should be included in the "ideal" therapy office?

Select up to 5 responses.

 1. Therapist's family photos

<ul style="list-style-type: none">2. Therapist's personalized décor3. Diplomas or credentials4. Bright lighting5. Soft, dim lighting6. Multicultural art or décor7. Religious or spiritual symbols or objects8. A home-like atmosphere9. A professional atmosphere10. A clock facing the client11. A bookshelf12. A window13. A soothing color palette14. Plants15. Facial tissues16. Other <p>vi. What do you think should not be included in the "ideal" therapy office? Select up to 5 responses.</p> <p>1. Same list of possible responses as previous question.</p> <p>b. If no:</p> <ul style="list-style-type: none">i. How much attention do you pay to the interior design of the spaces you spend time in?ii. What do you think should be included in the "ideal" therapy office? Select up to 5 responses.iii. What do you think should not be included in the "ideal" therapy office? Select up to 5 responses.

Note. Branching occurs at Question 4, when clients and non-clients are presented different sets of questions depending on whether or not they have been to therapy.

Figure 2.

<p><i>Survey Questions to Therapists</i></p> <ul style="list-style-type: none">1. What is your gender identity?2. What is your race/ethnicity?3. What is your age?4. What is your degree?5. How long have you been practicing as a mental health provider?6. How much attention do you pay to the interior design of the spaces you spend time in?7. How much attention do you pay to how your office looks and comes across to your clients?

8. How much attention do you think your clients pay to the interior design of your office?
9. How much of an effect do you think your office has on how your clients view you as a therapist?
10. How much of an effect do you think your office has on your clients' therapy outcomes?
11. Do you design your office more for yourself or for your clients?
12. What do you think should be included in the "ideal" therapy office?
13. What do you think should not be included in the "ideal" therapy office?

Responses from Clients

Figure 3.

How much attention do you pay to the interior design of the spaces you spend time in?
100 responses

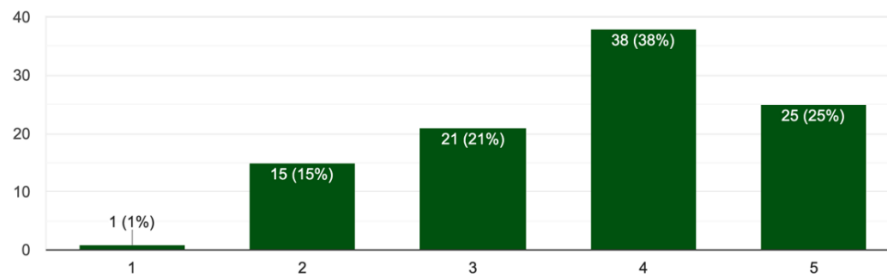


Figure 4.

How much attention do you pay to how your therapist's office looks and comes across?
100 responses

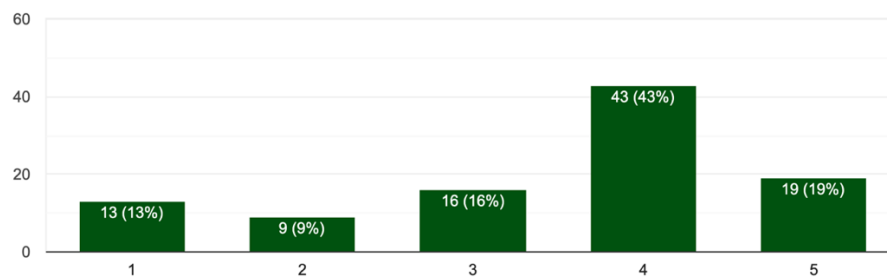


Figure 5.

Interior Design of the Psychotherapist's Office

How much of an effect do you think your therapist's office has on how you view them as a therapist?

100 responses

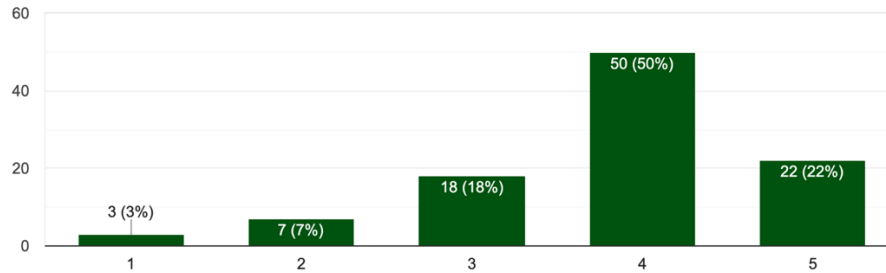
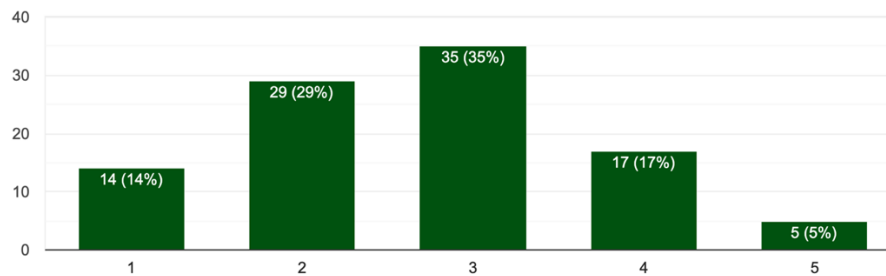


Figure 6.

How much of an effect do you think your therapist's office has on your therapy outcomes?

100 responses

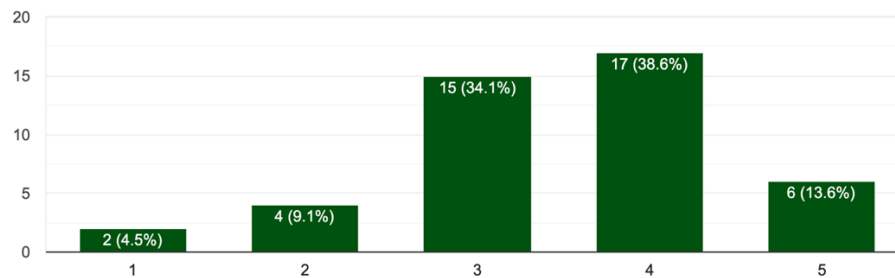


Responses from Non-Clients

Figure 7.

How much attention do you pay to the interior design of the spaces you spend time in?

44 responses



Responses from Therapists

Figure 8.

Interior Design of the Psychotherapist's Office

How much attention do you pay to the interior design of the spaces you spend time in?

34 responses

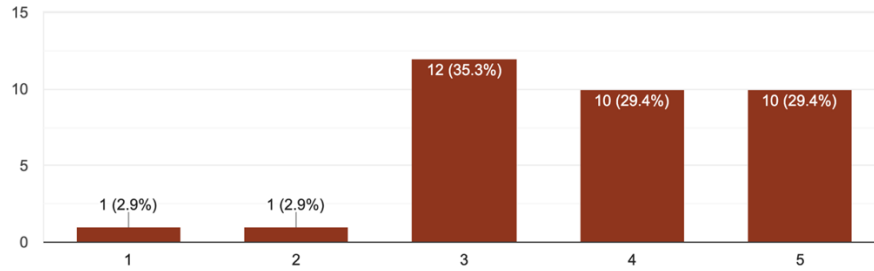


Figure 9.

How much attention do you pay to how your office looks and comes across to your clients?

34 responses

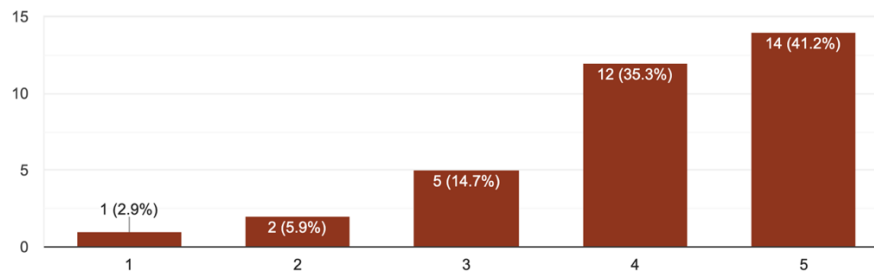


Figure 10.

How much attention do you think your clients pay to the interior design of your office?

34 responses

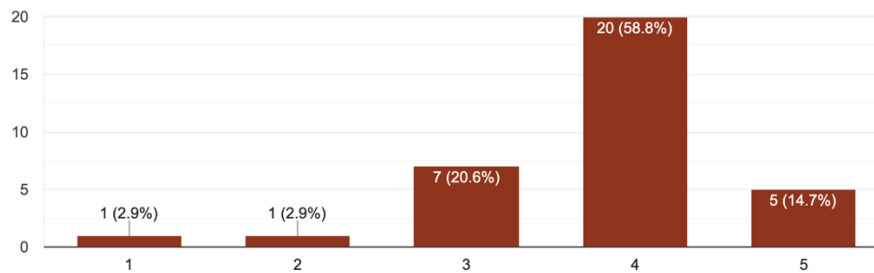


Figure 11.

Interior Design of the Psychotherapist's Office

How much of an effect do you think your office has on how your clients view you as a therapist?

34 responses

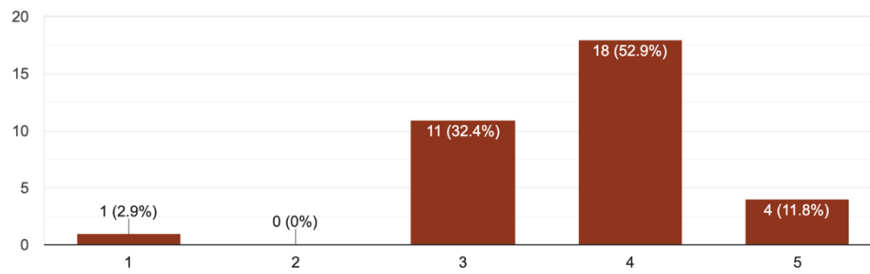


Figure 12.

How much of an effect do you think your office has on your clients' therapy outcomes?

34 responses

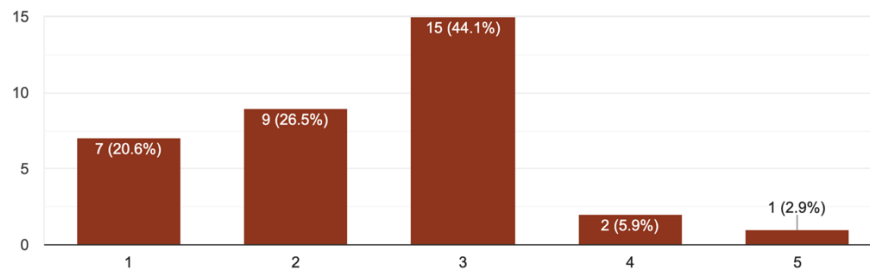
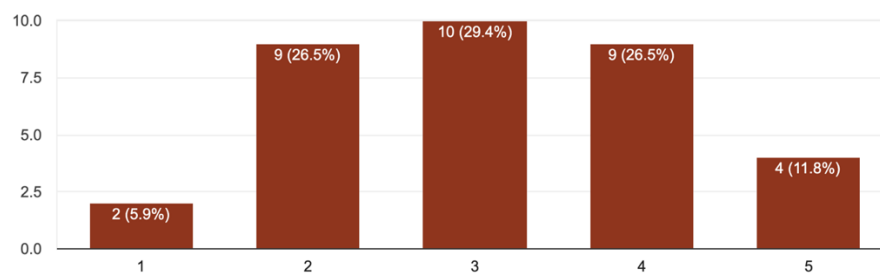


Figure 13.

Do you design your office more for yourself or for your clients?

34 responses



Responses from Clients

Figure 14.

Interior Design of the Psychotherapist's Office

What do you think SHOULD be included in the "ideal" therapy office? Select up to 5 responses.

100 responses

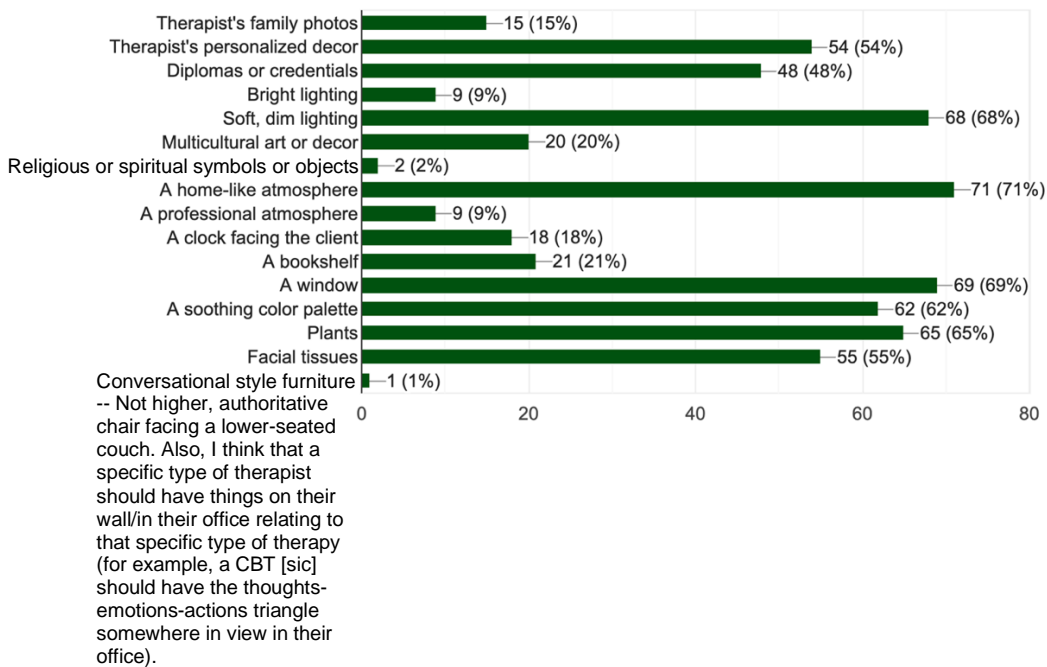
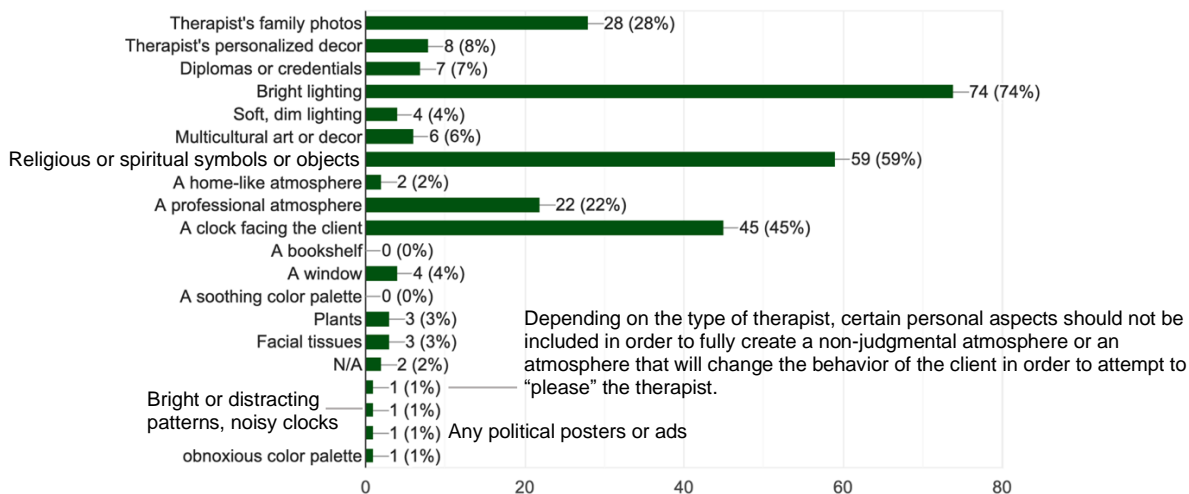


Figure 15.

What do you think SHOULD NOT be included in the "ideal" therapy office? Select up to 5 responses.

100 responses



Interior Design of the Psychotherapist's Office

Responses from Non-Clients

Figure 16.

Even if you have not been to therapy, what do you think **SHOULD** be included in the "ideal" therapy office? Select up to 5 responses.

44 responses

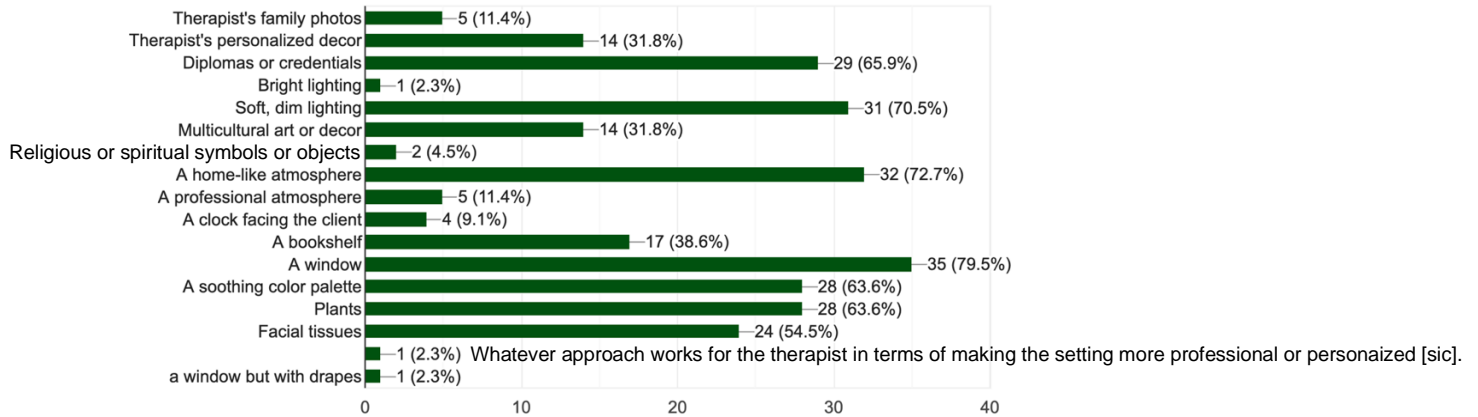


Figure 17.

What do you think **SHOULD NOT** be included in the "ideal" therapy office? Select up to 5 responses.

44 responses

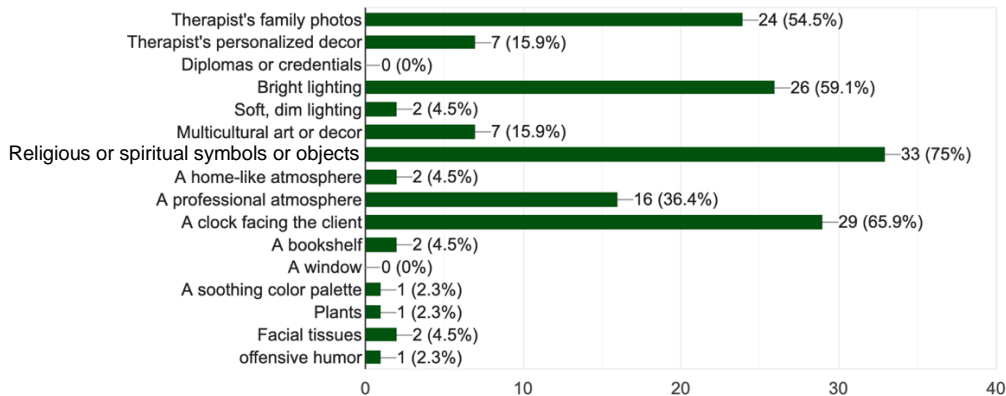


Figure 18.

Interior Design of the Psychotherapist's Office

What do you think SHOULD be included in the "ideal" therapy office? Select up to 5 responses.

34 responses

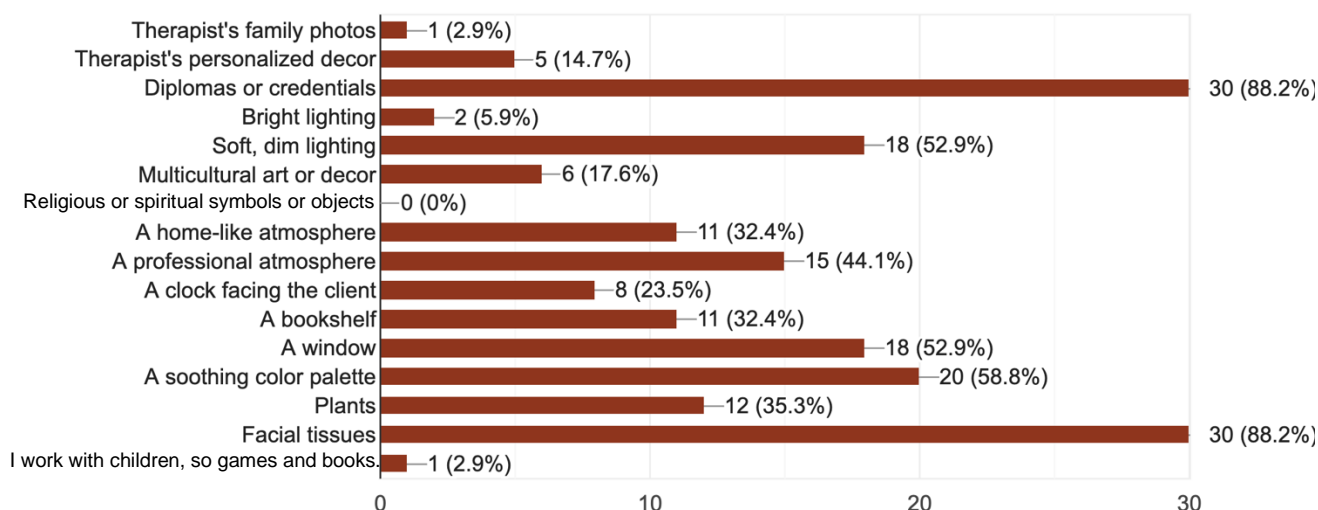


Figure 19.

What do you think SHOULD NOT be included in the "ideal" therapy office? Select up to 5 responses.

34 responses

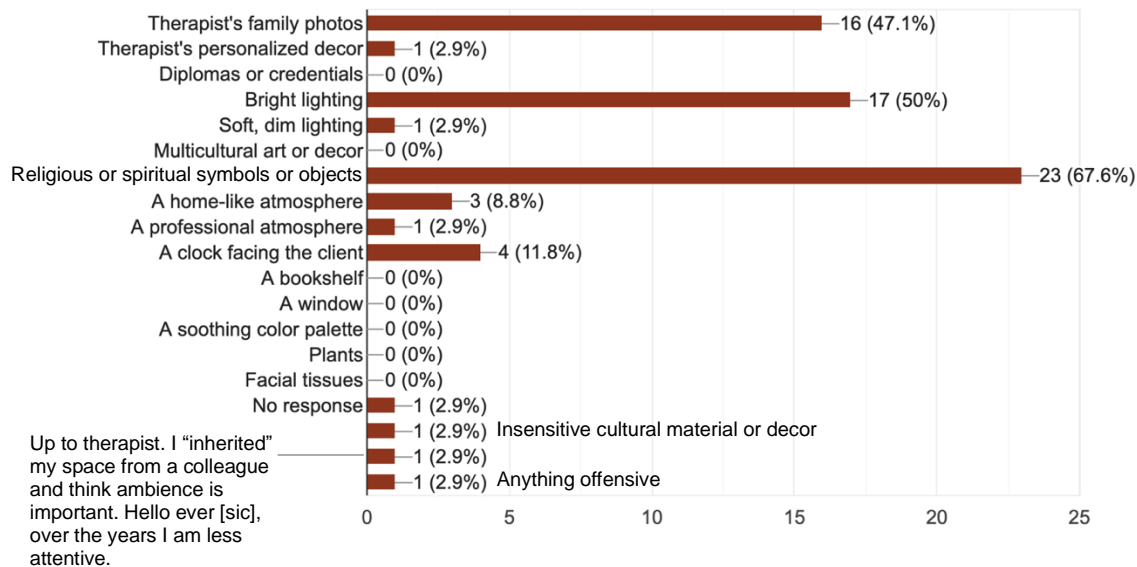


Figure 20.

Scatterplot of Clients' and Therapists' Attention to Interior Design in General versus Their Ratings for the Office's Effect on Clients' Treatment Outcomes

Interior Design of the Psychotherapist's Office

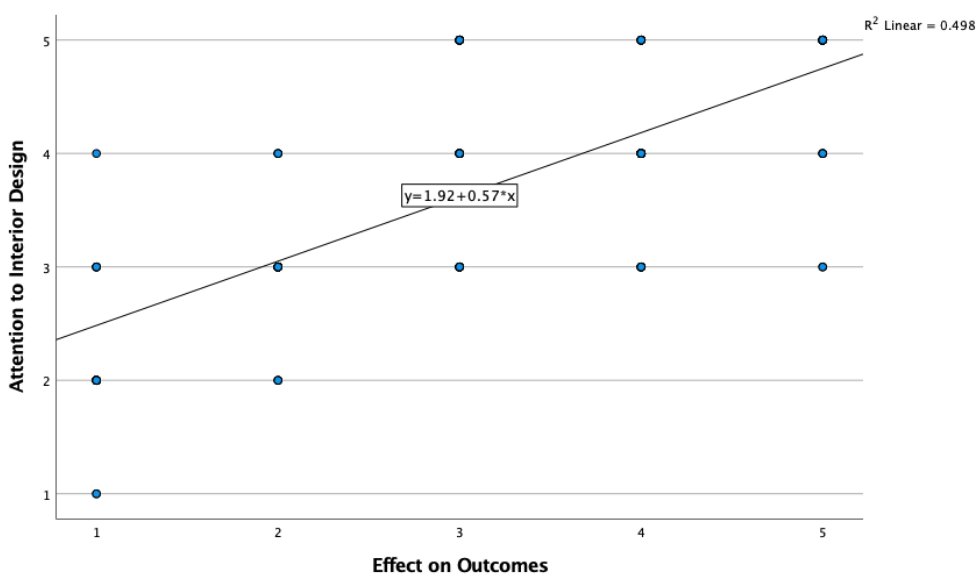


Figure 21.

Scatterplot of Clients' and Therapists' Attention to the Therapist Office versus Their Ratings for the Office's Effect on Clients' Treatment Outcomes

